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HEALTH CARE FACIL1..

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOUNTAIN VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 1880 BYPASS ROAD WINCHESTER, TN 37398		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to update the care plan for two residents (#13, # 14) of twenty-four residents reviewed.</p> <p>The findings included: Resident #13 was admitted to the facility on July 12, 2007, with diagnoses including Alzheimer's Dementia, Arthritis, Cardiomegaly, Psychotic Disorder and Heart Failure.</p>	F 279	<p>Disclaimer Submission of this response and plan of correction is not A legal admission that deficiency exists or that this Statement of deficiencies was correctly cited, and is Also not to be construed as an admission of interest Against the facility, the Executive Director or any Employees, agents or other individuals who draft or may Be discussed in this response and plan of correction. In addition, preparation and submission of this plan Of correction does not constitute an admission of? Agreement of any kind by the facility or the correctness Of any conclusions set forth in this allegation by the Survey agency. Accordingly, the facility has prepared And submitted this plan of correction prior to the resolution Of any appeal which may be filed solely because of the Requirements under state and federal law that mandate Submission of a plan of correction within (10) ten days Of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of Correction within this time frame should in no way be Considered or construed as agreement with the allegations Of non-compliance or admissions by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Pam Reed

TITLE

Executive Director

(X5) DATE

7/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOUNTAIN VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 BYPASS ROAD WINCHESTER, TN 37398		
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F 279	<p>Continued From page 1</p> <p>Medical record review of the MDS (Minimum Data Set) dated June 4, 2011, revealed the resident had severe cognitive impairment and required assistance of one to two people for all activities of daily living.</p> <p>Medical record review of the Plan of Care dated February 18, 2011, revealed no documentation of the use of a Geri chair with an attached tray table.</p> <p>Observation on June 27, 2011, at 2:30 p.m., and June 28, 2011, at 10:45 a.m. and 2:30 p.m., revealed the resident seated in the Geri chair with the tray table in use in front of the resident. Observation revealed no observations of meals being served or activities taking place.</p> <p>Interview with the Assistant Director of Nursing Services, on June 28, 2011, at 9:10 a.m., in the Advanced Alzheimer's Care Unit nursing station confirmed the care plan was not updated to include the use of the attached tray table as an intervention.</p> <p>Resident #14 was admitted to the facility on September 12, 2008, with diagnoses including Multiple Sclerosis and Left Sided Hemiplegia. Medical record review of the Minimum Data Set (MDS) dated March 5, 2011, revealed the resident has range of motion (ROM) impairment of both upper and lower extremities bilaterally.</p> <p>Review of an Occupational Therapy Screening dated June 14, 2011, revealed "...has left resting hand splint..."</p> <p>Medical record review of the Nursing Care Plan</p>	F 279	<p>F279</p> <p>Resident #13 care plan was updated to reflect current use of tray with geri chair. Resident #14 care plan was updated to reflect splint and current self exercise program by IDT consisting of Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Registered Nurse. Both resident #13 and #14 were screen by therapy for continued appropriateness of treatment plans.</p> <p>Facility recognizes residents with assistive devices have potential to be affected. Audits of current residents will be done to identify assistive devices care plan will be updated to reflect care by IDT consisting of Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Registered Nurse and therapy.</p> <p>Education will be done with nursing staff who develop and update care plans on identifying proper interventions for residents with assistive devices by RN Clinical Consultant.</p> <p>Monitoring of care plans updates will be through audit of 10% of residents with assistive devices will be conducted weekly x 4 then monthly x 2 by IDT consisting of Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Registered Nurse. Any concerns will be reported and discussed in QAA.</p>	7/15/11	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOUNTAIN VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 1360 BYPASS ROAD WINCHESTER, TN 37398		
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F 279	Continued From page 2 dated January 15, 2011, and updated on June 7, 2011, revealed no specific interventions for the resident's impaired range of motion and no interventions regarding the resident's hand splint or exercise bands. Observation on June 28, 2011, at 3:00 p.m., revealed the resident lying in bed with a splint to the left hand and forearm and exercise bands attached to the side-rails. Interview with the resident on June 28, 2011, at 3:00 p.m., in the resident's room confirmed the resident has Multiple Sclerosis and Left Sided Hemiplegia with impaired strength and ROM in both upper and lower extremities. Interview with the Rehabilitation Director on June 28, 2011, at 3:15 p.m., in the facility's conference room revealed the resident was not receiving any therapy or restorative nursing services currently. Further interview revealed the resident has a self-exercise program that the resident performed with thera-bands on the bed rails. Interview with the Rehabilitation Director confirmed the resident did wear a hand splint to prevent contractures of the left hand. Interview with the Interim Director of Nursing (DON), on June 29, 2011, at 8:45 a.m., in the DON's office, confirmed the care plan did not address the resident's hand splint or self exercise program.	F 279			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371			

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F 371	<p>Continued From page 3</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation of the serving line and interview during the preparation of the lunch meal on June 27, 2011, the facility failed to maintain an acceptable food temperature for two of four foods sampled.</p> <p>The findings included:</p> <p>Observation of the serving line at 12:35 p.m., on June 27, 2011, revealed the following:</p> <ol style="list-style-type: none"> 1) The serving line had begun plating food at 12:15 p.m., food trays had been served to two nursing units, and about twenty residents were presently eating in the main dining room. 2) Observations included the pureed and chopped chicken being served. 3) After calibrating a thermometer, the assistant dietary manager took temperatures of the chicken breast, baked beans, chopped chicken and pureed chicken. 4) The pureed chicken temperature measured 122 degrees and was pulled from the serving line. 5) The chopped chicken temperature measured 134 degrees and was pulled from the serving line. 	F 371	<p>F 371</p> <p><u>Corrective Actions for Targeted Residents:</u></p> <p>A limited number of individuals were affected by the deficient practice. Food was immediately removed from the steam table and replaced. Pureed and Ground meats were replaced on the steam table at the correct holding temperature.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u></p> <p>All residents have a potential to be affected by this practice.</p> <p><u>Systemic Changes:</u></p> <p>Vents were closed over the steam table. New steam table will be purchased. Bids being obtained.</p> <p>In-service training was provided by Department Manager with all dietary employees on June 28, 2011. In-service completed on temperature policy, how to read a thermometer and when to record food temperatures</p> <p>1) end of cooking 2) Beginning of service and 3) mid point of service. All temperatures will be posted on the Department logs and reviewed daily by the DSM.</p>		

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F 371	Continued From page 4 Interview with the assistant dietary manager, at 12:50 p.m., on June 27, 2011, adjacent to the serving line, verified the temperatures of the pureed and chopped chicken were below the required 140 degrees.	F 371	<u>Monitoring:</u> The ED and DSM will complete an ED dietary checklist weekly through September 15, 2011 and then monthly thereafter to include a review of the meal temperature logs. The DSM will complete a daily start up checklist to include monitoring of daily meal temperatures. All checklist/audits will be reviewed for trends with results and action plans reported in quarterly QA&A minutes.	7/15/11	